



**CLINICAL NURSE SPECIALIST  
RESPIRATORY  
REFERRAL FORM**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_  
\_\_\_\_\_

**GP NAME:** \_\_\_\_\_

**REASON FOR REFERRAL**

Education as inpatient:

On going community follow up:

Do they require home O2:

(Please do district nurse referral, ensure protocol LTOT followed)

Pulmonary Rehab Required

**EXPECTED DATE DISCHARGE:** \_\_\_\_\_ (please do not refer on date of discharge)

**PATIENT AWARE OF REFERRAL: YES  
NO**

**SMOKER: YES  
NO**

**MEDICATIONS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REFERRAL SOURCE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**FAX TO 8042  
KEEP ORIGINAL IN PATIENT NOTES  
Incomplete referrals will not be excepted**